Survey of practice annual reports

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SUMMARY. A questionnaire was sent to those practices known by the Royal College of General Practitioners to have produced annual reports. Practices were asked what data they included, to whom the report was circulated, what problems and benefits they encountered, and their opinion of the government's proposal to encourage such reports. The data most frequently included in reports related to practice workload, and the main benefit which respondents mentioned was facilitation of planning within the practice. Few practices used data derived from outside the practice and several commented on the difficulty of obtaining good quality data from the practice. Although annual reports are useful as internal documents, standardization of definitions and format, with support from family practitioner committees and health authorities is essential if more practices are to be encouraged to produce such documents and if the information obtained from them is to have a broader role in planning for primary health care.

Introduction

LACK of systematic operational data about general practice is a major obstacle in the development of primary care.[1] The interest, resources and expertise to collect and interpret data have been lacking at practice, family practitioner committee and national level. In 1985 the Royal College of General Practitioners responded to the lack of information at practice level by supporting the production of practice annual reports.[2]

The primary objective for such documents was to aid planning within the individual practice.[3] However, the recent government white paper *Promoting better health* emphasized the role of annual reports in providing information for the holders of the general practitioners' contract: 'The government sees advantages in practices submitting annual reports to FPCs and health boards about the range of services offered and the workload undertaken in the period in question'.[4] Another suggested use of annual reports is to increase patients' involvement in the practice and to act as a method of accountability of practitioners to the users of the service.[5]

Little or no evaluation has been made of whether annual reports would achieve these objectives. In particular, the problem of practices lacking the skills and resources for producing reports has not been addressed. It is not known how many practices are currently producing reports or what data the reports contain. The first description of an annual report was published in 1980.[6] In recent years the RCGP has been collecting examples of annual reports and so far 44 practices have submitted one or more reports (RCGP, personal communication).

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This paper reports a survey of these practices, aimed at documenting what data they included in their reports, to whom the reports are made available and the advantages and problems encountered in producing such documents.

Method

A list of practices who had sent a copy of one or more annual reports to the RCGP was obtained. This contained the addresses of 44 practices. One overseas practice was listed but excluded from the study. A questionnaire was sent to a named partner in the remaining 43 practices, with one reminder if necessary. The questionnaire asked when the practice started producing reports and whether it continued to do so. Detailed enquiry was made about the most recent report; whose responsibility it was, what information it contained, any problems encountered and any benefits gained. Both open and closed questions were used. Respondents were asked whether they thought practices should be required to produce standardized annual reports. Finally information was sought about the practice, its size, administrative aspects, and relationship with patients.

Results

One questionnaire was returned by the Post Office as the practice had dissolved with no forwarding address. All of the remaining 42 practices replied, although two of these reported that they had never produced an annual report — one had produced a detailed practice profile, and the other a report on the local general practitioner maternity unit. Overall, a 100% response rate was obtained from the 40 practices still in existence who had submitted one or more annual reports to the RCGP.

The earliest date a practice report had been produced was 1970. Twenty eight of the practices (70%) started producing annual reports in 1984 or later. All but one practice continued to produce regular reports, and in 37 cases (93%) this was done annually. In 30 of the practices (75%) a partner had the primary responsibility for producing the report; in three cases this was the responsibility of the practice manager and in seven it was a shared responsibility. The agencies and individuals to whom a copy of the practice's last report was sent are given in Table 1. Individual practices extended the list to include hospital consultants, social services departments, members of parliament and Prince Charles. Nine practices (23%) displayed their report in the surgery waiting room.

Table 1. Agencies/individuals sent a copy of the most recent practice report.

	Number (%) of practices sending copy of report ($n=40$)
RCGP	31 (*78*)
Other GPs	30 (*75*)
Family practitioner committee	25 (*63*)
University department of general practice	20 (*50*)
Community health council	11 (*28*)
Patient representatives	10 (*25*)
District health authority	5 (*13*)
Regional advisor	5 (*13*)

n = total number of practices.

Practices were asked whether or not certain data were included in their last report (Table 2). The data most commonly reported (over 80% of practices) were: consultation and visiting rates; changes in list size; proportion of elderly patients; immunization rates and number of cervical smears. An open question asked what other important data were included. The most frequent responses were: personnel and staff changes (18 practices, 45%) and contributions from team members (14, 35%). Other items listed included details of students and trainees, contraceptive services, research interests and publications, a practice profile and data on admissions. Two practices included some assessment of the health needs of the practice population, in one case using local census data.

The most commonly noted benefit of the practice report, mentioned by 22 practices (55%), was that the document aided planning. In 15 cases (38%), documentation itself was cited as a benefit, and in 14 cases (35%), the boost to morale, establishment of team spirit and improvements in communication were mentioned. Only three practices mentioned the ability to compare their data with those from other practices as a benefit.

The most frequently mentioned disadvantages of the enterprise were the time (21 practices, 53%), effort (12, 30%) and money (four, 10%) involved. Four practices reported that motivating practice members to contribute was a problem, and two reported that the final product was potentially threatening to the practice. Four practices reported a problem obtaining good quality data, and one mentioned the lack of similar data against which to compare their findings.

When asked whether practice reports should follow a standard format 29 practices (73%) agreed that they should, many adding that there was also need for a more idiosyncratic component. Of those who were against a standard format, three thought this would cause an unacceptable loss of individuality, and one that such a requirement would reduce motivation. On the question of whether production of such a report should be a requirement of general practice, 22 (55%) thought it should be. When asked to comment on this proposal, supporters mentioned accountability to patients, but opponents commented that compulsory reports would be of a low standard.

The final section of the questionnaire aimed to discover what sort of practices produced reports. List sizes ranged from 2000 to 23 000, with a median of 9000. Partnership size ranged from one to 10, with a median of five. Thirty eight practices (95%) were involved with teaching, 36 (90%) employed a practice manager and 28 (70%) had a computer. Thirty seven (93%) produced a practice information leaflet and five (13%) had a patient participation group.

Table 2. Data included in the most recent practice report.

	Number (%) of practices including data ($n=40$)[a]
Population	
List size	24 (*60*)
% change in list size over last year	33 (*83*)
% of patients under 5 years of age	22 (*55*)
% of patients aged 65 years and over	34 (*85*)
Patient turnover (% leaving list)	23 (*58*)
Number and causes of death in practice population	21 (*53*)
Workload	
Number of consultations per patient per year	39 (*98*)
Number of visits per patient per year	34 (*85*)
Number of night visits per year (23.00–07.00 hours)	31 (*78*)
Number of visits by deputizing service per year (if used)	5 (*13*)
Number of referrals per consultation	16 (*40*)
Number of referrals per patient per year	17 (*43*)
Number of prescriptions per consultation	13 (*33*)
Number of investigations per consultation	5 (*13*)
Prevention	
% coverage of immunization programmes	34 (*85*)
Number of cervical smears taken	35 (*88*)
% of women smeared within last 5 years	26 (*65*)
% of adults under 65 years with blood pressure measured	19 (*48*)
% of adults under 65 years with smoking behaviour recorded	15 (*38*)
Number of diabetics on practice list	19 (*48*)
Number of hypertensives on practice list	18 (*45*)
Other	
Practice accounts	9 (*23*)
Courses attended over previous year	16 (*40*)
Aims and objectives for the subsequent year	32 (*80*)

n = total number of practices.
Missing data for some questions and only 12 practices used a deputizing service.

Discussion

As it is not known how many practices produce annual reports, it is impossible to estimate whether the sample studied here is representative. It is likely that those who sent the RCGP a copy of their first or subsequent report did so because of enthusiasm for the enterprise or because they felt that this was an innovation worth reporting. The survey is therefore likely to be biased in favour of good quality reports from enthusiasts.

Three possible objectives for annual reports were mentioned earlier — to aid planning in the practice, to provide information to the family practitioner committee and to increase accountability to users of the service. The results of this study suggest that the first objective is achieved in the majority of cases. Thirty two practices (80%) reported that their annual report contained aims and objectives for the subsequent year, and 22 (55%) listed planning as one of the benefits of the exercise. Data recorded by most practices would aid planning of both workload and service development. For example, all but one practice included a consultation rate, which could be used to estimate the number of appointment slots needed for the subsequent year. Data on immunization rates and cervical cytology, included by 85% and 88% of practices respectively, could be used to plan future programmes and monitor their effectiveness. The finding that 37 practices (93%) continue to produce reports annually suggests that they find the project useful and that a 12-month interval is an appropriate one for planning.

It is the usefulness of practice reports to those outside the practice which is more difficult to ascertain. The finding that most reports were sent to the RCGP, the family practitioner committee and other general practitioners suggests a wider role is being sought. It is likely that practices use other practices' reports in a comparative exercise, whether for workload data such as night visit rates, or performance data such as prescribing. The use of reports to compare practices was mentioned as both a benefit and a problem. The finding that 29 practices (73%) thought reports should follow a standard format suggests that practices feel this to be important. For even informal comparison it is essential that a standard data set is included, and that there are agreed definitions of terms such as consultation rate.

If practice reports are to be used as a monitoring exercise by the family practitioner committee, a suggestion endorsed by the

proposed new contract,[7] good quality data becomes essential. The government proposes that practices collect data on hospital usage (including diagnostic services), cervical cytology and immunization rates. For most of the practices surveyed this would involve adding to the contents of their present documents, especially the requirement for data on hospital usage. Even if valid data can be collected, enormous problems of interpretation remain[8,9] without further information about the practice population. The practices surveyed, who were enthusiasts, noted the time, effort and expense involved. For less motivated practices, support from the family practitioner committee in all three areas would be necessary. Family practitioner committees could encourage the production of practice reports by offering to supply the data they routinely collect, together with an analysis of its distribution, such as the Prescription Pricing Authority currently provides.

Only five practices (13%) sent a copy of their report to the health authority. Health authorities have access to local morbidity and demographic data and, through their departments of community medicine, may find practice data useful to monitor public health. It is likely that with further computerization in hospitals, health authorities will be able to provide breakdowns of investigation and referral rates at a practice level. Departments of community medicine have been encouraged to produce annual reports, after consultation with local authorities, family practitioner committees and other relevant local bodies.[10] There is clearly potential for collaboration between the local authority, health authority, family practitioner committee and individual practices to produce reports that are complementary, comparable and useful.

The third potential use of practice reports is in communication with the patient. Nine practices (23%) displayed their report in the waiting room, and 11 (28%) sent a copy to their community health council. These low figures contrast with the high figure for production of patient information leaflets (37 practices, 93%).

The practices in this survey were large and had a high level of administrative support (70% were computerized, 90% employed a practice manager). Even these practices had problems with time, effort and finance, and were worried about the quality of data produced. If annual reports are to become a compulsory activity (a proposition supported by 55% of respondents), support from the family practitioner committee and health authority is essential.

References

1. Arthur Anderson and Co. *Report of a study of family practitioner services administration and the use of computers.* London: Arthur Anderson, 1984.
2. Royal College of General Practitioners. *Quality in practice. Policy statement 2.* London: RCGP, 1985.
3. Gray DJP. Practice annual reports. In: Gray DJP (ed). *Medical annual 1985.* Bristol: Wright, 1985.
4. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Promoting better health (Cm 249).* London: HMSO, 1987.
5. Association of Scientific, Technical and Managerial Staffs/Medical Practitioners Union. *The future organisation of primary care.* London: ASTMS, 1986.
6. McGuiness B. Why not a practice annual report? *J R Coll Gen Pract* 1980; **30**: 744.
7. Department of Health and the Welsh Office. *General practice in the National Health Service. A new contract.* London: Department of Health and the Welsh Office, 1989.
8. Moore AT, Roland MO. How much variation in referral rates among general practitioners is due to choice? *Br Med J* 1989; **289**: 500-502.
9. Jarman B, Bosanquet N, Rice P, *et al.* Uptake of immunisation in district health authorities in England. *Br Med J* 1988; **296**: 1775-1778.
10. Committee of Inquiry into the Future Development of the Public Health Function. *Public health in England (Cmnd 289).* London: HMSO, 1988.

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